PATIENT NUMBER

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(800) 243-4675

PATIENT'S NAME _____
Last First Initial

BLOOD PRESSURE	PULSE

DATE OF EXAM _____ DOCTOR'S SIGNATURE _____

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EXTERNAL

Skin _____ Patient's Chief Complaint _____

Lymph Nodes _____

Pain in TMJ? Yes No Masseter Bulge: Present _____ Missing _____

Joint Sounds? Right _____ Left _____

Clicking _____ Crepitation _____

Molar Relationships

Right CL I CL II CL III Left CL I CL II Cl III

Crossbites _____

Overbite ____ mm Over jet ____ mm Open Bite ____ mm Edge to Edge _____

Fremitus _____

Where is the first contact in C.R.? _____

Direction of slide R _____ L _____ Forward _____

Canine Guidance _____ Group function _____

Anterior Guidance _____

Interferences: RW _____ RB _____

LW _____ LB _____

SOFT TISSUES:

Lips _____ Buccal Muccosa _____

Tongue _____ Vestibules _____

Hard Palate _____ Floor of Mouth _____

Soft Palate _____

Salivary Glands _____ Pharynx _____

Cheeks _____ Tonsils _____

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FACIAL SUPPORT:

Lip Line Thin _____ Normal _____ Full _____

Commissure Sagging _____ Normal _____ Folding _____

Lost Vertical Dimension _____ mm

CONDITION OF PARTIAL DENTURE

Age of Partial _____
Relined yes no

CONDITION OF FULL DENTURE

Age of denture _____
Relined yes no
How long has patient been edentulous? _____

Form No. T452OS

OCCLUSAL & SOFT TISSUE EXAMINATION